WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PSYCHOTHERAPY ATTACHMENT (PA/PSYA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Providers should refer to their service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization/Psychotherapy Attachment (PA/PSYA) to the Prior Authorization Request Form (PA/RF) and physician prescription (if necessary) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

GENERAL INSTRUCTIONS
The information contained in the PA/PSYA is used to make a decision about the amount and type of psychotherapy that is approved for Wisconsin Medicaid reimbursement. Thoroughly complete each section and include any material that would be helpful to understand the necessity of the services being requested. Where noted in these instructions, material from personal records may be substituted for the information requested on the form.

When submitting the initial PA request for a particular individual, complete the entire PA request. For continuing PA on the same individual, it is not necessary to rewrite Elements 1-18, unless new information has caused a change in any of the information in these elements (e.g., a different diagnosis, belief that intellectual functioning is, in fact, significantly below average). When there has been no change to the information in Elements 1-18, submit a photocopy of Elements 1-18 along with updated information in Elements 19-36. Medical consultants reviewing the PA requests have a file containing the previous requests, but they must base their decisions on the clinical information submitted, so it is important to present all current relevant clinical information. For example, a depressed person may overeat or eat too little, or may sleep a lot or very little; therefore, recording simply that the recipient is depressed does not present the relevant clinical picture. The documentation should include details on the signs and symptoms the recipient presents due to the diagnosis.

Prior authorization for psychotherapy is not granted when another provider already has an approved PA for psychotherapy services for the same recipient. In these cases, Wisconsin Medicaid recommends that the recipient request that previous providers notify Wisconsin Medicaid that they have discontinued treatment with this recipient. The recipient may also submit a signed statement of his or her desire to change providers and include the date of the change. The new provider's PA may not overlap with the previous provider's PA.

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Age — Recipient
Enter the age of the recipient in numerical form (e.g., 16, 21, 60).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — PROVIDER INFORMATION

Element 4 — Name — Performing Provider
Enter the name of the therapist who will be providing treatment.

Element 5 — Performing Provider's Medicaid Provider Number (not required)
Enter the eight-digit Medicaid provider number of the performing provider.

Element 6 — Telephone Number — Performing Provider
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

Element 7 — Discipline — Performing Provider
Enter the discipline (credentials) of the therapist who will be providing treatment. The discipline should correspond with the name listed in Element 4.

Element 8 — Name — Prescribing Provider
Enter the name of the physician who wrote the prescription for psychotherapy.

Element 9 — Prescribing Provider's Medicaid Provider Number
Enter the eight-digit Medicaid provider number of the physician who wrote the prescription for psychotherapy.

SECTION III — DOCUMENTATION

Element 10 — Diagnosis
Enter the diagnosis codes and descriptions from the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), using all fives axes.

Element 11 — Date Treatment Began
Enter the date of the first treatment by this provider.

Element 12 — Diagnosed by
Indicate the procedure(s) used to make the diagnosis.

Element 13 — Consultation
Indicate whether there was a consultation done with respect to the recipient's diagnosis and/or treatment needs. Indicate why the consultation was needed.

Element 14 — Results of Consultation
Summarize the results of this consultation or attach a copy of the consultant's report.

Element 15 — Presenting Symptoms
Enter the presenting symptoms and indicate the degree of severity. This information may be provided as a part of an intake summary that may be attached to this request form.

Elements 16-17 — Intellectual Functioning
Indicate whether intellectual functioning is significantly below average (e.g., an I.Q. below 80). If "yes," indicate the I.Q. or intellectual functional level.

Element 18 — Historical Data
This information may be submitted in the form of an intake summary, case history, or mental status exam as long as all information relevant to the request for treatment authorization is included.

Element 19 — Present GAF (DSM)
Enter the global assessment of functioning scale score from the most recent version of the DSM. For continuing PA requests, indicate whether the recipient is progressing in treatment, using measurable indicators when appropriate.

Element 20 — Present Mental Status / Symptomatology
Indicate the recipient's current mental status and symptoms. For continuing authorization requests, indicate the progress that has been made since the beginning of treatment or since the previous authorization. This information may be supplied in the form of an intake summary or a treatment summary as long as the summary presents a crystallization of the progress to date. It is not acceptable to send progress notes which do not summarize the progress to date.

Element 21 — Updated / Historical Data
For continuing requests, indicate any new information about the recipient's history which may be relevant to determine the need for continued treatment.

Element 22 — Treatment Modalities
Indicate the treatment modalities to be used.

Element 23 — Number of Minutes Per Session
Indicate the length of session for each modality.

Elements 24-25 — Frequency of Requested Sessions and Total Number of Sessions Requested
If requesting sessions more frequently than once per week, please indicate why they are needed. If a series of treatments that are not regular is anticipated (e.g., frequent sessions for a few weeks, with treatment tapering off thereafter), indicate the total number of hours of treatment requested, the time period over which the treatment is requested, and the expected pattern of treatment. The total hours must match the quantity(ies) indicated on the PA/RF.

Example: A provider requests 15 hours of treatment over a 12-week period. The recipient attends a one and one-half hour group every other week (six groups for a total of nine hours). There are one-hour weekly individual sessions for four weeks and every other week for the following four weeks (six individual sessions for a total of six hours).

Element 26 — Psychoactive Medication
Indicate all the medications the recipient is taking which may affect the recipient's symptoms that are being treated. Indicate whether a medication review has been done in the past three months.

Element 27 — Rationale for Further Treatment
Indicate the symptoms or problems in functioning that require further treatment. If recipient has not progressed in treatment thus far, indicate reasons for believing that continued treatment is helping.

Element 28 — Goals / Objectives of Treatment
Summarize current goals/objectives of treatment. A treatment plan may be attached in response to this item.

Element 29 — Steps to Termination
Providers should indicate how they are preparing the recipient for termination. When available, indicate a planned date of termination.

Element 30 — Family Members
Adequate justification is required if an individual provider provides services to more than one family member in individual psychotherapy.

Element 31 — Signature — Performing Provider
Wisconsin Medicaid requires the performing provider's signature to process the PA request. Read the Prior Authorization Statement before dating and signing the attachment.

Element 32 — Date Signed
Enter the month, day, and year the PA/PSYA was signed by the performing provider (in MM/DD/YYYY format).

Element 33 — Signature — Recipient (optional)
Signature indicates the recipient has read the form. Signature is optional.

Element 34 — Date Signed
Enter the month, day, and year the PA/PSYA was signed by the recipient (in MM/DD/YYYY format).

Element 35 — Signature — Supervising Provider
Signature required only if the performing provider is not a physician or psychologist.

Element 36 — Date Signed
Enter the month, day, and year the PA/PSYA was signed by the supervising provider (in MM/DD/YYYY format).

Other Required Information

In addition to the above information, Wisconsin Medicaid requires the following to process the PA request:

- Attach a copy of the signed and dated prescription for psychotherapy.* The initial prescription must be dated within three months of receipt by Wisconsin Medicaid. Subsequent prescriptions must be dated within 12 months of receipt by Wisconsin Medicaid.

* If the performing provider is a physician, a prescription need not be attached.